Correspondence

Patients' Presence in Prenatal Screening

To THE EDITOR: I found the epitome, "Advances in Prenatal Screening," by Ganiats and Baughan in the March issue interesting but puzzling.[1] There appear to be two parallel ways of thinking about prenatal care issues: patient-centered and technologic. The "public health" approach as described by Ganiats and Baughan represents the technologic approach exclusively. Education of the patient as to important issues in managing her own pregnancy is not even considered. Certainly, they have covered nicely all the tests to do at what point in pregnancy, but patients and physicians get into trouble because of what patients do or do not do, or what physicians tell them or do not tell them, and how the communication goes wrong. When an outcome is bad, technology often does not help the mother or the physician, only the malpractice attorney. Let's get the *patient* back into "advances in prenatal screening."

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Blastocystis hominis

To THE EDITOR: Babb and Wagener, in their retrospective study of *Blastocystis hominis* in the November 1989 issue,[1] compare their findings with ours[2] and come to the opposite conclusion, namely that "*B hominis* is a potential pathogen that can in some patients lead to diarrhea and abdominal pain." Let us examine the basis on which they base this not-very-emphatic endorsement of its pathogenicity.

Some 3% of 2,700 patients who had stool examinations done during a one-year period were found to have *B hominis* in their stools. Of medical records examined, 65 contained relevant clinical information. Of these 65, however, fewer than three stool specimens were submitted by 24 persons. Sawitz and Faust, whose exhaustive study is still our only guide in this regard, conclude that only about two thirds of *Entamoeba histolytica* infections are discovered in two stool examinations, by a combination of techniques including but not limited to stained slides.[3] The other 41 patients had at least three stool examinations, which by Sawitz and Faust's calculations would reveal about 80% of such infections. There are no comparable statistics for *Dientamoeba fragilis* and *Giardia lamblia.* Our own experience, based on patients who had a minimum of six stool examinations, each examined not once but by two licensed microbiology technologists and one of us (E.K.M.), showed it was possible to miss *Giardia* on six such consecutive examinations. Thus, we can conclude that it is probable that some of these 65 patients had undetected amebic or flagellate infections.

In this study, about half (33 of 65) received no treatment, either because they were asymptomatic from the start or because their symptoms cleared up promptly. Of the remaining 32, half (16) had recognized parasites. Both *E histolytica* and *Giardia* respond to treatment with metronidazole, and dientamoebiasis is often asymptomatic. Thus, nothing can be concluded from the favorable response of these 16 patients.

There remain 16 patients who were proper subjects for the study. How many of these had even three stool examinations we do not know, but only 3 of them had even a single follow-up examination. Most became asymptomatic after treatment (it is impossible to tell how many because the authors do not differentiate between the two different patient groups), but these statistics do not justify any conclusions as to the pathogenicity of *B hominis.* Although costly and time-consuming, an adequate number of stool examinations must be done—and preferably checked as we did by several persons—with an adequate number of follow-up examinations after treatment, before drawing any conclusions as to the pathogenicity of an organism whose appearance in the stools of a symptomatic person may be as coincidental as that of *Entamoeba coli* or *Endolimax nana.* Babb and Wagener imply that we consider "functional bowel syndrome" as a convenient catch-all for those patients with *B hominis* in whom we were unable to find recognized pathogens. On the contrary, all those to whom this diagnosis was assigned fulfilled all the recognized criteria for this diagnosis at follow-up examinations for an average of 30 months.

Most of the articles cited by Babb and Wagener are single-case reports. They do not mention the work of Miller and Minshew,[4] who were unconvinced of the pathogenicity of *Blastocystis* on the basis of their own study of 11 patients and a review of the literature, or that of Chen and co-workers,[5] who by using immunoblot analysis were unable to detect any serologic response from four patients with a diarrheal syndrome associated with the presence of *B hominis,* in contrast to what is seen with known intestinal pathogens such as *Giardia.*

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Espresso Maker's Wrist

To THE EDITOR: Food service workers are subject to a variety of cumulative trauma disorders, including carpal tunnel syndrome (grocery checkers) and pressure neuropathy of the deep palmar branch of the unlar nerve ("pizza cutter's palsy").[1,2] Reported here is a case of de Quervain's tenosynovitis in a novel occupational context.

A 41-year-old restaurant owner was noted by this physician-customer to be wearing an elastic bandage on his right (dominant) wrist. Upon inquiry, he reported a two-month history of gradually increasing pain of the radial aspect of the joint. The pain was exacerbated each time he inserted spigots

containing fresh coffee grounds into an espresso machine with a rotating motion of the handle—a maneuver that he repeated 80 to 100 times a day. When doing this task, he would grasp the spigot handle with his supinated right hand, rotating the handle to his right with an abrupt ulnar deviation of the wrist. He had no previous injuries involving the right upper extremity and had no history of arthritis or tendinitis. He had elected to use the elastic wrap without medical consultation and reported only minimal improvement with its use.

On examination the wrist was moderately tender over the abductor pollicis longus. No erythema or swelling was apparent, and there was no crepitus over the radial border of the wrist with thumb abduction. Sensory and motor function in the hand was intact. The result of a Finkelstein's test, however, was positive. The patient was informed that he had early de Quervain's tenosynovitis. He was advised to rest the affected part, to take an over-the-counter nonsteroidal anti-inflammatory medication, and to consider obtaining a wrist splint. After three weeks' rest and medication, symptoms were almost entirely resolved. He adapted to this occupational disability by using his opposite hand to insert spigots into the espresso machine, taking care to avoid any abrupt or strenuous maneuvers in the process. There has been no recurrence of symptoms in the intervening three months.

De Quervain's tenosynovitis has been noted occupationally in association with repetitive hand movements—historically in "washerwoman's sprain," involving the wringing of clothes, and more recently in assembly-line work.[3] While the prevalence of this disorder among espresso makers is unknown, the recent surge in popularity of espresso drinking may place additional persons at risk. Physicians indulging in this dietary habit should maintain a high degree of vigilance for affected workers and suggest alternative work practices when appropriate.

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A Pathologist's View of Mohs' Micrographic Surgery

To the Editor: As a pathologist, I find several major problems with the article by Darmstadt and Steinman in the February issue reviewing the use of Mohs' micrographic surgery.[1] First, the amount of tissue that can be placed on a cryostat chuck is generally less than 1 cm in diameter and less than 0.5 cm thick; therefore, large specimens require, in many cases, hours to orient, incise, divide, ink, and properly process and interpret. Second, while this parallel margin concept is theoretically sound, in real practice it is impossible to obtain a truly flat surface that is exactly parallel to the cryostat's cutting blade. Therefore, one actually "faces off" or cuts through the margin to obtain an appropriate flat sheet of tissue to place on the glass slide. Hence, one is not looking at the actual margin but at a layer of tissue that is generally from one to several millimeters away from the margin. Third, anyone who has substantial experience interpreting frozen sections is aware that there are frequently instances where dysplastic dermal adnexal structures may be mistaken for nests of malignant epithelium. The Mohs technique does not allow the relationship between these nests and the overlying epidermis to be seen. Also, the so-called permanent or deeper sections are even farther from the true surgical margin than is the frozen section slide. In contrast, classic perpendicular sections allow one to see not only whether the margin is involved but how close to the margin any tumor resides, and deeper sections into the paraffin block do not destroy this relationship as is the case with the Mohs technique.

As stated in the article, it may be a "unique" feature of this technique that a surgeon is involved in "all phases of the procedure," but this may not be cause for embracing the procedure. Just as a pathologist does not do surgical procedures as competently as a surgeon, I seriously doubt that a surgeon is as qualified as a pathologist to make histopathologic diagnoses on frozen section, particularly if an unexpected lesion is seen. Metastatic renal cell carcinoma, metastatic breast carcinoma, and many other lesions that dermatologists have very little experience recognizing may be present in the skin. While in some ways I would welcome dermatologists taking over this time-consuming and often frustrating process and while the Mohs technique may be appropriate in a rare case, I hope that the disadvantages of this extremely labor-intensive, expensive technique are properly appreciated by your readers.

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Ruminations of an Aspiring Californian

To the Editor: In recent years, the list of health problems attributable to life-style has grown beyond those due to diet, physical activities, and noxious substances. We report a case of acute airway obstruction associated with two relatively recent trends: adult orthodontics and California cuisine.

Not long after moving to California from the East Coast, on the advice of her dentist and with the encouragement of a Southern California specialist in adult orthodontics, a 31-year-old woman began a course of orthodontia to correct malocclusion. Treatment progressed with exemplary results and her bands were removed. She received a removable retainer that fit beneath her hard palate and was instructed to wear it even while eating.

At a lunch meeting, while discussing the benefits of a low-fat diet over a platter of al dente vegetables, she suddenly stood and raised both hands to her neck in the international sign of choking. Her companion did a prompt Heimlich maneuver, ejecting an intact, nearly raw two-inch-long piece of broccoli. The broccoli had lodged in her pharynx between her trachea and the back of the retainer, completely occluding the airway.

To our knowledge, this is the first report of choking associated with an orthodontic appliance. Patients should consider removing their retainers before eating.

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